

Achieving Managed Care Accountability by Ending the ERISA Preemption Defense*

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The managed care industry has been criticized for sacrificing the quality of patient care for fiscal considerations. Although managed care is responsible for a variety of innovations and improvements to our nation's healthcare system, the fact remains that a substantial number of managed care enrollees have been harmed as a result of cost-cutting measures. When injuries occur, managed care plans enjoy almost complete immunity from tort liability under the Employee Retirement Income Security Act (ERISA). This Note argues that the abuses of managed care can be remedied by exposing health plans to tort liability where their fiscal decisions result in patient injury. Moreover, this Note argues that by limiting ERISA preemption to its proper, narrow scope, and by bringing ERISA preemption into conformity with preemption jurisprudence generally, ERISA does not bar tort claims against managed care organizations.

I. INTRODUCTION

On the morning of May 21, 1990, Basile Pappas was transported to Haverford Community Hospital in Pennsylvania complaining of an inability to walk and numbness of the arms, abdomen, chest, and legs.¹ Pappas was diagnosed with an epidural abscess, which was compressing his spinal cord in his neck.² Pappas's primary care physician and Haverford's emergency room physician and staff neurologist agreed that Pappas was experiencing a "neurologic emergency" that required prompt treatment.³ Unfortunately, Pappas's condition required expertise and equipment that surpassed Haverford's capabilities.⁴ Shortly after noon, Pappas's physicians made arrangements to transfer him to a special spinal cord trauma unit at Thomas Jefferson University Hospital.⁵ Before transfer, however, United States Healthcare, Inc. (USHC), Pappas's health maintenance organization (HMO), refused to authorize Pappas's

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¹ See *Pappas v. Asbel*, 675 A.2d 711, 713 (Pa. Super. Ct. 1996). Mr. Pappas's episode actually began the previous day when he visited his primary care physician complaining of neck and shoulder pain. See *id.* Pappas was treated with steroids and released. See *id.*

² See *id.*

³ See *id.*

⁴ See *id.*

⁵ See *id.*

transfer from Haverford to Jefferson on the grounds that "Jefferson was not an approved facility" under the terms of the HMO agreement.⁶ USHC continued to refuse transfer after numerous attempts on the part of Pappas's physicians to convince them otherwise.⁷ Finally, an acceptable alternative hospital was selected although USHC's authorization procedures delayed Pappas's transfer by another half-hour.⁸ By the time USHC approved Pappas's transfer to an appropriate facility, it was too late. Basile Pappas now suffers from permanent quadriplegia resulting from prolonged compression of his spinal cord by the abscess.⁹

The tragic case of *Pappas v. Asbel* illustrates perhaps the most alarming flaw in the so-called managed care revolution. The switch from traditional fee-for-service medicine to managed care has been dramatic. For example, in 1980 it was estimated that only five to ten percent of Americans with employer-sponsored health insurance were enrolled in managed care plans.¹⁰ By 1987, the percentage had skyrocketed to sixty percent.¹¹ By 1992, over forty million Americans were enrolled in an HMO.¹² Managed care organizations¹³ (MCOs) have the laudable purpose of decreasing healthcare costs by eliminating unnecessary medical treatments and expenditures.¹⁴ The legal mechanisms that have traditionally guaranteed healthcare quality and safeguarded patient's interests, however, are oriented toward a fee-for-service type of healthcare delivery system.¹⁵ These legal safeguards, predicated on a fee-for-service system, are ill suited to address and counterbalance the forces that seek to reduce costs in exchange for reasonable healthcare access and quality.¹⁶ Moreover, MCOs typically exploit preemption

⁶ See *id.*

⁷ See *id.*

⁸ See *id.*

⁹ See *id.* Approximately three hours passed between diagnosis of Pappas's emergent condition and USHC's final transfer authorization. See *id.*

¹⁰ See BARRY R. FURROW ET AL., HEALTH LAW § 8-1, at 309 (1995).

¹¹ See *id.*

¹² See *id.*

¹³ The term "managed care organization" refers to the integration of healthcare payment, administration, and delivery and includes a variety of managed care structures such as health insuring corporations, health maintenance organizations, group models, independent practitioner associations, preferred provider organizations, exclusive provider organizations, utilization review organizations, and hospitals. See Barry R. Furrow, *Managed Care Organizations and Patient Injury: Rethinking Liability*, 31 GA. L. REV. 419, 430-31 (1997); FURROW, *supra* note 10, § 8-1, at 308-11 (describing the theory, practice, and structure of managed care).

¹⁴ See Furrow, *supra* note 13, at 427-42 (discussing the theory of managed care).

¹⁵ See Edward B. Hirshfeld & Gail H. Thomason, *Medical Necessity Determinations: The Need for a New Legal Structure*, 6 HEALTH MATRIX 3, 9-10 (1996) (describing the foundation of medical malpractice rooted in an implied contract between an individual patient and an individual physician).

¹⁶ See Clark C. Havighurst, *Making Health Plans Accountable for the Quality of Care*, 31

under the Employee Retirement Income Security Act of 1974 (ERISA)¹⁷ to avoid liability for adverse patient outcomes by artificially divorcing health plan management from the delivery and quality of healthcare services.

The hallmark of the managed care revolution is the integration of healthcare management, finance, and delivery. Under the old fee-for-service model, payment for healthcare services was administered by an insurance scheme that was completely independent from the physician's practice. Integration combines the delivery and management of healthcare services under one banner. Thus, management, finance, and delivery of healthcare services are all constituent parts of the larger whole of the modern MCO. Within this integrated enterprise, the fiscal and management arms of the MCO necessarily make *de facto* treatment decisions that restrict the discretion of healthcare professionals and directly impact patient outcomes. Yet, MCOs are able to take refuge in the fiction that health plan *management* is a separate and distinct function from healthcare *delivery*. As a result, MCOs have exploited a framework that allows them to simultaneously enjoy the benefits of both a unitary and a divided organizational form.

On the unitary side, MCOs are able to direct the work of physicians and exert a coercive influence over their clinical judgments in order to decrease utilization and cut costs. However, in the face of adverse patient outcomes, MCOs shed their unitary guise and adopt a compartmentalized form in order to isolate medical malpractice liability at the physician level. Such a system disconnects the considerable cost-cutting power wielded by MCOs from meaningful accountability for the consequences. Moreover, many courts view the current state of medical malpractice law to require physicians to answer for adverse patient outcomes flowing from cost-containment decisions. Because MCOs can separate cost-containment actions from legal accountability, they are able to sacrifice healthcare quality, for the sake of financial savings, with relative impunity. The imposition of direct medical malpractice liability against MCOs can bring a fair and equitable allocation of accountability to the nation's healthcare system and put an end to the fiction that MCOs merely manage healthcare and do not play a role in patient outcomes.

This Note will argue that the application of direct tort liability against MCOs for medical malpractice is appropriate because MCOs should be responsible and accountable when their cost containment policies cause physicians to deliver sub-standard healthcare. Part II will describe the various strategies employed by MCOs to reduce costs and utilization of healthcare resources. In particular, this Part will explain prospective utilization review and its implications for healthcare quality, patient outcomes, and, most importantly, MCO liability. Part III will describe and critique the shortcomings of the various theories of liability currently

GA. L. REV. 587, 610-11 (1997) (discussing how MCOs do a poor job of equitably refocusing liability such that they avoid responsibility for the quality of care delivered under their control).

¹⁷ 29 U.S.C. §§ 1001-1461 (1994).

available to plaintiffs in actions against MCOs. Part IV will analyze the confusion surrounding the scope of ERISA preemption. In light of the United States Supreme Court's decisions in *Cipollone v. Liggett Group, Inc.*¹⁸ and *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*,¹⁹ it appears that the Court generally is receptive to the idea of a diminished scope of federal preemption. Despite the abuses of ERISA preemption within the managed care industry, the shrinking scope of preemption has not been extended into the ERISA context. Without generalizing this narrower construction of preemption to ERISA, state attempts to remedy defects in managed care will fail. Therefore, the managed care revolution requires a modification of the prevailing doctrine of federal preemption of state tort liability for MCOs. Part V will explain how direct MCO tort liability for negligent utilization review decisions should be implemented. Specifically, the elements of the cause of action, the establishment of the standard of care, and the role of utilization review expert witnesses in proving the cause of action will be outlined.

II. MANAGED CARE COST CONTAINMENT AND THE DANGERS OF UTILIZATION REVIEW

A. Cost Containment and Reduced Utilization of Healthcare Services

MCOs employ a variety of administrative and fiscal mechanisms in order to reduce healthcare costs and discourage unnecessary care and treatment.²⁰ One management strategy is to pay physicians on a capitation basis.²¹ Two main features of capitation schemes are flat-rate payments to providers on a per patient basis and flat-rate payments based on diagnosis.²² Another cost-containment

¹⁸ 505 U.S. 504 (1992) (finding that federal smoking legislation does not preempt certain state law claims).

¹⁹ 514 U.S. 645 (1995) (declining to broadly interpret the ERISA preemption provision).

²⁰ See generally Hirshfeld & Thomason, *supra* note 15, at 26–29 (discussing both direct and indirect influences over medical decisionmaking including utilization review, case management, practice guidelines, physician profiling, financial incentives, financial withholds, and capitation).

²¹ See Patricia A. Danzon, *Tort Liability: A Minefield for Managed Care?*, 26 J. LEGAL STUD. 491, 498 (1997) (stating that capitation works “to shift from passive payment of providers, based on fee-for-service or costs incurred, to various forms of fixed fee payment for a comprehensive episode or period of care, regardless of the volume or cost of services actually delivered”); James F. Henry, Comment, *Liability of Managed Care Organizations After Dukes v. U.S. Healthcare an Elemental Analysis*, 27 CUMB. L. REV. 681, 703 (1996–1997) (describing the re-allocation of the risk of high costs from the insurer to the physician under capitation systems).

²² See Larry J. Pittman, *ERISA's Preemption Clause and the Health Care Industry: An Abdication of Judicial Law-Creating Authority*, 46 FLA. L. REV. 355, 362 (1994) (“One of the first prospective payment systems was established when the federal government created the

strategy involves preferred provider arrangements between MCOs and individual healthcare professionals in which healthcare providers receive the right to treat the MCO's subscribers in exchange for participation in the managed care system.²³ Additionally, MCOs typically require prior authorization before approving reimbursement.²⁴ This prior authorization, known as utilization review, may include practice guidelines, treatment protocols, and pre-approved treatment plans.²⁵

Utilization review is one of the most widely used and, potentially, one of the most troubling cost-containment mechanisms employed by MCOs.²⁶ Utilization review may result in the delivery of healthcare that exceeds, equals, or falls below the accepted standard of care. Ideally, MCOs seek to achieve utilization review that approximates the standard of care. When utilization review causes care to surpass the prevailing standard, waste, inefficiency, and over-utilization result. On the other hand, when utilization review causes healthcare delivery to fall below the accepted standard of care, adverse patient outcomes are likely to occur. Utilization review has been a fixture of healthcare management for decades. Under the traditional fee-for-service system, utilization review was done retrospectively.²⁷ With retrospective utilization review, healthcare services were delivered to the patient *before* cost, reimbursement, and medical necessity were considered. The insurer would review the physician's actions after the fact and either grant or deny reimbursement. Denial of reimbursement meant that the insurer, and not the physician or patient, absorbed the cost of the uncovered service.²⁸ For this reason, retrospective utilization review was not entirely effective at controlling healthcare costs and reducing unnecessary treatment. Once the physician prescribed and delivered a service or performed a procedure, the act was done. Retrospective utilization review could not undo the past. Thus,

diagnosis-related groups (DRGs) for reimbursement of medical expenses to medicare patients in 1983.”).

²³ See Danzon, *supra* note 21, at 498 (“Managed care plans typically restrict coverage to a network of ‘preferred providers,’ who agree to accept lower fees and/or assume financial risk in return for the higher volume that results from participation in the network.”).

²⁴ See *id.*

²⁵ See *id.* Practice guidelines, treatment protocols, and pre-approved treatment plans are cost-containment tools in which MCOs prescribe the treatments, tests, medications, and other facets of treatment authorized under the plan.

²⁶ See *Wickline v. State*, 239 Cal. Rptr. 810, 811–12 (Cal. Ct. App. 1986) (discussing potential negative implications that erroneous utilization review decisions can have on patient outcomes).

²⁷ See John D. Blum, *An Analysis of Legal Liability in Health Care Utilization Review and Case Management*, 26 HOUS. L. REV. 191, 192–93 (1989); Barry R. Furrow, *Medical Malpractice and Cost Containment: Tightening the Screws*, 36 CASE W. RES. L. REV. 985, 986–87 (1986).

²⁸ See *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1326–27 (5th Cir. 1992) (discussing the general principles and operation of prospective utilization review systems).

retrospective utilization review, while preserving physician autonomy and emphasizing patient preferences, was subject to abuse by providers who prescribed treatments that would later prove to be unnecessary, wasteful, and inefficient.

As knowledge and understanding of geographical variations in treatment and medical necessity grew, insurance companies and MCOs began to implement strategies to prevent unnecessary care and expenses.²⁹ Thus, the use of concurrent and prospective utilization review by MCOs became widely accepted. Concurrent utilization review requires contemporaneous monitoring of non-emergency treatment decisions to determine their appropriateness and necessity.³⁰ In managed care systems that employ prospective utilization review, healthcare providers must secure advance authorization before rendering medical treatment.³¹ As the *Pappas*³² case graphically illustrates, prospective utilization review can have tragic consequences when the reviewer makes an incorrect or delayed assessment of the necessity of a given treatment or procedure. The entire prospective utilization review process is rife with dangers. First, the individual performing the utilization review is typically not on the scene and must communicate with the treating physicians by telephone. Such physical distance makes it nearly impossible for the utilization reviewer to make a truly informed decision regarding the necessity of the patient's treatment.³³ Second, most utilization reviewers are not physicians and many lack any training or education in the health sciences at all.³⁴ Yet, attending physicians must yield in judgment to utilization review decisions made by these non-physicians. Thus, prospective utilization review has evolved into an absurd system in which distant, unqualified, and ill-informed reviewers are empowered to veto the sound clinical decisions of treating physicians. Such a system invites human tragedy resulting from erroneous utilization review determinations.

B. *The Link Between Utilization Review Decisions and Clinical Decisions*

The link between utilization review decisions and clinical treatment decisions is so strong that the line separating administrative functions from treatment

²⁹ See Hirshfeld & Thomason, *supra* note 15, at 18–23 (discussing the evolution of the concept of medical necessity).

³⁰ See generally Blum, *supra* note 27, at 192–93 (explaining utilization review); Linda V. Tiano, *The Legal Implications of HMO Cost Containment Measures*, 14 SETON HALL LEGIS. J. 79, 80 (1990) (same).

³¹ See *Wickline*, 239 Cal. Rptr. at 811.

³² *Pappas v. Asbel*, 675 A.2d 711 (Pa. Super. Ct. 1996).

³³ See *Physicians Form Group to Counter Managed Care Policies*, Associated Press, Nov. 29, 1994, available in 1994 WL 10109993 ("The plans leave decisions on the best treatment to insurance company clerks sitting at computer terminals hundreds of miles away . . .").

³⁴ See *id.*

functions within managed care entities is virtually non-existent.³⁵ The blurring of the distinction between treatment decisions and treatment delivery has important consequences. Cost-containment strategies create a "professional conflict" between healthcare professionals and MCOs.³⁶ Physicians and other healthcare professionals have legal, ethical, and fiduciary obligations to place the health and well-being of their patients ahead of all other considerations.³⁷ Yet, MCOs exist primarily to reduce costs and ensure a minimum level of care for their subscribers. This dichotomy in purpose, between healthcare professionals and MCOs, results in tension. As *Pappas* demonstrates, a physician's concern for her patient often collides head-on with a MCO's concern for cost containment. Due to the disparity in power between MCOs and physicians, the concerns and priorities of the MCOs typically prevail. MCOs derive their power over physicians by controlling the physician's access to patients. As more Americans become enrolled in managed care plans, physicians have increasingly been forced to affiliate their practices with MCOs in order to retain patients and keep their practices solvent.³⁸ Because MCOs effectively control the supply of customers/patients, physicians are at the mercy of MCOs. Thus, the MCO holds the power to take away the physician's customers/patients in the event that the physicians do not adhere to MCO policies and procedures such as utilization review directives.³⁹

³⁵ See Hirshfeld & Thomason, *supra* note 15, at 4. Hirshfeld and Thomason state that:

[T]here is an area where coverage decisions and medical decisions merge. When a health plan agrees to cover health care services, the contract with the beneficiary generally specifies that the services must be paid for when they are reasonable and necessary for the diagnosis or treatment of an illness or injury suffered by the beneficiary. In the event of a dispute between the health plan and the beneficiary about whether covered services should be paid for, a determination about whether the services were reasonable and necessary must be made. This determination, while a coverage decision, is also a medical decision.

... [T]he medical decision made as a part of a coverage decision is not independent from the medical decisions made by the physician and patient ... The coverage decision becomes the treatment decision ...

Id.

³⁶ See Henry, *supra* note 21, at 716-17 (discussing the conflict between physicians' obligation to provide high quality care and to place the patient's well-being before all other considerations and the MCO's obligation to reduce healthcare costs).

³⁷ See *id.*; see also HIPPOCRATIC OATH, reprinted in TABER'S CYCLOPEDIA MEDICAL DICTIONARY 902 (Clayton L. Thomas ed., F.A. Davis Co. 17th ed. 1993).

³⁸ See Hirshfeld & Thomason, *supra* note 15, at 39 (discussing how the economic pressures exerted by MCOs alter physicians' practices as a result of the paucity of available patients).

³⁹ See *All Things Considered* (National Public Radio broadcast, Apr. 14, 1997) (interviewing Dr. Tom Giltanen) available in 1997 WL 12832820; *60 Minutes: HMO; the Pros and Cons of Having an HMO Take Care of Your Medical Needs* (CBS television broadcast,

C. *The Bifurcation of Responsibility for Patient Care*

Another consequence of the melding of management and treatment decisions is the bifurcation of responsibility for patient care.⁴⁰ Bifurcation refers to the split in accountability such that responsibility for healthcare financing and cost rests with one group (the MCO), while legal responsibility for healthcare services and quality rests with another group (healthcare professionals).⁴¹ This bifurcation of accountability and responsibility is possible because medical malpractice law is arranged toward a traditional fee-for-service healthcare system and has not kept pace with the transition to managed care.⁴² Such a legal perspective ignores the reality that MCOs are engaged in the virtual practice of medicine by controlling the physician's practice and restricting treatment options through utilization review.⁴³ Thus, bifurcation results in an inequitable and disparate allocation of accountability. MCOs are able to exercise a high degree of control over healthcare delivery with relatively little accompanying accountability or exposure to liability. Conversely, physicians enjoy a small measure of control and autonomy while bearing the lion's share of the responsibility for poor patient outcomes.⁴⁴

D. *The Benefits and Shortcomings of Managed Care*

The above discussion is not to suggest that managed care's impact on the

Oct. 1, 1995) (interviewing Dr. Robert Plancey and Dr. Rex Green) *available in* 1995 WL 2729812.

⁴⁰ See Havighurst, *supra* note 16, at 587.

⁴¹ See *id.*

⁴² See *id.* at 611–12.

⁴³ See *id.* at 618 (“[A]n MCO has too many ways to influence the clinical decisions of medical specialists to permit it to deny that it is in the business of practicing medicine or otherwise to escape liability for breakdowns of the system over which it presides.”). But see Barbara A. Noah, *The Managed Care Dilemma: Can Theories of Tort Liability Adapt to the Realities of Cost Containment?*, 48 MERCER L. REV. 1219, 1231–32 (1997) (arguing that physicians can practice high quality medicine in managed care systems without breaching the malpractice standard of care).

⁴⁴ See Havighurst, *supra* note 16, at 611–13. Havighurst explains that:

MCOs have been able to avoid legal accountability for the medical services they arrange for, manage, and finance only because the law on this subject embodies a paradigm of medical care that has not been updated to embrace the concept of corporately managed services It is simply ironic that a legal system which has finally seen fit to empower MCOs to control the cost of health care remains fastidious about making them also responsible for its quality. Both legislatures and courts seem to be in de jure denial of the de facto reality of corporate medical care.

Id.

nation's healthcare system has been entirely negative. Managed care has been somewhat successful in streamlining health service utilization through such innovations as reductions in hospital admissions, increased use of less costly primary care physicians and nurse practitioners, and moving certain treatments and procedures from in-patient to out-patient settings.⁴⁵ MCOs have also been credited with improving the health status of their subscribers through preventive care and the careful monitoring and selection of participating physicians.⁴⁶ Further, some studies suggest that the overall quality of the American healthcare system has not suffered as a result of the transition to managed care.⁴⁷ Despite the positive inroads that managed care has made in reducing costs without an aggregate decline in healthcare quality or an increase in poor patient outcomes, doubts regarding managed care's commitment to quality continue to persist.⁴⁸ A substantial body of anecdotal evidence suggests that a significant number of patients are harmed as a result of MCO cost-containment policies.⁴⁹ Pappas illustrates this point. Clearly, MCOs bear the brunt of the blame for instances of poor quality healthcare in the eyes of both the public and the medical community.⁵⁰ Physicians feel constrained in their ability to act in the best interest of their patients as a result of practice restrictions imposed by their MCOs. Patients perceive a managed care system, as reported in the popular media, that places profit and cost containment over their well-being and ability to obtain appropriate care.⁵¹ Consequently, litigants should increasingly look to hold

⁴⁵ See Hirshfeld & Thomason, *supra* note 15, at 35.

⁴⁶ See Havighurst, *supra* note 16, at 593-94 (discussing the positive contributions that managed care has made to the general quality of healthcare).

⁴⁷ See Hirshfeld & Thomason, *supra* note 15, at 35-36; see also HARVARD MEDICAL MALPRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK 6 (1990) (estimating that eight times as many patients suffered an injury from medical negligence as filed malpractice claims in the state of New York before the widespread implementation of managed care).

⁴⁸ See Noah, *supra* note 43, at 1230 ("Patients who experience bad outcomes under plans that employ cost-control strategies... often attribute these bad outcomes to the MCO's emphasis on cost containment, and they argue that the plan's structure provides disincentives for quality care."). See generally GEORGE ANDERS, HEALTH AGAINST WEALTH: HMOs AND THE BREAKDOWN OF MEDICAL TRUST (1996) (describing the effects of managed care on individuals and the health care industry); Havighurst, *supra* note 16, at 590-92 (discussing the current backlash against managed care); Hirshfeld & Thomason, *supra* note 15, at 36 (discussing anecdotes of patient harm resulting from health plans that refused medical care).

⁴⁹ See Hirshfeld & Thomason, *supra* note 15, at 36-37 (suggesting that individual instances of adverse outcomes are not reflected in empirical research because either the adverse outcomes reported in the media did not result in permanent harm or the patient obtained appropriate medical care outside the MCO after being denied coverage).

⁵⁰ See David R. Olmos, *Survey Finds Wide Distrust of HMO Care*, L.A. TIMES, Nov. 6, 1997, at A1 (reporting on the generally negative public opinion of managed care according to researchers at Harvard University and the Kaiser Family Foundation).

⁵¹ See Laura Meckler, *Clinton Appoints Commission to Protect Patients*, Associated

MCOs liable for poor patient outcomes when the treating physician practices under the restrictions of cost containment. This liability is predicated on the idea that "corporate middlemen," who effectively direct treatment via utilization review decisions, should not be permitted to avoid legal responsibility for care provided by physicians laboring under the constraints of utilization restrictions.⁵² By erasing the artificial distinction between management of care and delivery of care and recognizing that, for the purposes of tort liability, MCOs stand on equal footing with physicians, MCOs can and should be exposed to liability when their utilization review determinations cause harm to plan enrollees.

III. DEFICIENCIES IN MANAGED CARE LIABILITY AND THE NEED FOR DIRECT LIABILITY FOR NEGLIGENT UTILIZATION REVIEW DECISIONS BY MANAGED CARE ORGANIZATIONS

A. *The Current State of Liability for Managed Care Organizations*

Clearly, MCO cost-containment and utilization review procedures can play a significant role in the chain of causation resulting in patient injury. Moreover, MCOs can set the stage for medical malpractice, on the part of healthcare professionals, by undermining physician autonomy through restrictions on available treatment options. Currently, there are several tort theories available to plaintiffs injured in managed care settings. Some of these theories allow plaintiffs to seek recovery directly against the responsible healthcare professional. Other theories allow plaintiffs to reach hospitals and, to a lesser extent, MCOs by channeling liability through physicians. Still other theories attempt to bypass vicarious liability and proceed directly against MCOs for adverse patient outcomes. Although most of the following theories of recovery have only been used against MCOs to a limited extent, they have a proven track record against physicians and hospitals. Just as liability evolved to extend from individual physicians to hospitals, it increasingly extends to include MCOs. Consequently, many of the tort theories that are applicable to physicians and hospitals are potentially of equal applicability to MCOs.⁵³

Press, Mar. 26, 1997, available in 1997 WL 4859270 (Calling for a patient's bill of rights, President Clinton noted that "many Americans worry that lower costs mean lower quality and less attention to their rights.").

⁵² See Havighurst, *supra* note 16, at 614.

⁵³ See generally Barry R. Furrow, *Enterprise Liability and Health Care Reform: Managing Care and Managing Risk*, 39 ST. LOUIS U. L.J. 79, 82-94 (1994) (discussing the evolution of malpractice liability from physicians to hospitals, and finally, to integrated delivery systems).

1. *History of Medical Malpractice Liability*

In the early days of medical negligence law, only physicians were liable in tort for malpractice. Hospitals were exempt from liability under the doctrine of charitable immunity.⁵⁴ Most hospitals were operated by religious and secular charitable organizations until the first half of the twentieth century. Courts extended charitable immunity to hospitals to protect their financial well-being, to encourage donations, and to ease the procurement of insurance.⁵⁵ In the 1940s, charitable immunity disappeared as hospitals began to evolve from strictly charitable institutions to more business-oriented institutions.⁵⁶ Courts also began to recognize that hospitals were in the best position to avoid the harm and loss of medical negligence.⁵⁷ The demise of charitable immunity had two important consequences. First, hospitals became subject to liability for the torts of their employees. Second, physicians and hospitals were positioned to share legal responsibility for malpractice.

Plaintiffs in medical malpractice suits could, theoretically, proceed against a hospital under the doctrine of respondeat superior⁵⁸ when the physician was directly employed by the hospital. However, the corporate practice of medicine doctrine effectively prevented physicians from entering into employee-employer relationships with hospitals.⁵⁹ The corporate practice of medicine doctrine is rooted in licensure laws and holds that only individuals, and not corporations, may practice medicine. Because a corporation, such as a hospital, could not

⁵⁴ See Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 385 (1994).

⁵⁵ See FURROW ET AL., *supra* note 10, § 7-1(a), at 290-91.

⁵⁶ See *President & Dirs. of Georgetown College v. Hughes*, 130 F.2d 810 (D.C. Cir. 1942) (declining to extend charitable immunity to a charitable teaching hospital); *Bing v. Thunig*, 143 N.E.2d 3 (N.Y. 1957) (abandoning charitable immunity and imposing general liability principles on hospitals).

⁵⁷ See *President & Dirs. of Georgetown College*, 130 F.2d. at 811.

⁵⁸ See W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS §§ 69-71 (5th ed. 1984); see also Joanne B. Stern, *Malpractice in the Managed Care Industry*, 24 CREIGHTON L. REV. 1285, 1286-88 (1991) (discussing vicarious liability theories in the medical malpractice context).

⁵⁹ See David D. Griner, Note, *Paying the Piper: Third-Party Payor Liability for Medical Treatment Decisions*, 25 GA. L. REV. 861, 891-92 (1991). Griner explains that:

Although hospitals were liable for the negligence of their employees and agents under the doctrine of respondeat superior, because a hospital could not be licensed to practice medicine, it could not properly supervise the medical staff in the performance of medical acts. Physicians were considered to be independent contractors because the hospital exerted no control over their activities.

practice medicine, a corporation could not be held liable for professional negligence.⁶⁰

2. *Expanding Liability Through the Application of Agency Principles*

In response to the limits on liability imposed by the corporate practice of medicine doctrine, courts began to focus on the control that hospitals exercised over physicians, independent of the lack of an employee-employer relationship, to apply agency principles to allow liability to run to hospitals for the torts committed by physicians.⁶¹ The related principles of vicarious liability, agency by estoppel,⁶² apparent agency, and ostensible agency⁶³ have evolved into viable theories of recovery against hospitals for medical malpractice.⁶⁴ The essence of these liability theories is the *patient's perception* of a principal-agent relationship between the physician and the hospital and the degree of control that the hospital holds over the physician and the treatment setting.⁶⁵ Cases against hospitals and MCOs brought under these agency theories often arise in emergency treatment contexts and focus on whether the patient reasonably and justifiably looked to the institution, as opposed to the individual practitioner, for treatment and whether the

⁶⁰ See *id.*

⁶¹ See Havighurst, *supra* note 16, at 596–601 (describing the evolution of the judicial application of agency-based liability to hospitals); see also Noah, *supra* note 43, at 1240–42 (discussing the theory of ostensible agency).

⁶² The *Restatement (Second) of Agency* defines “agency by estoppel” as:

One who represents that another is his servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such.

RESTATEMENT (SECOND) OF AGENCY § 267 (1958).

⁶³ The *Restatement (Second) of Torts* defines “ostensible agency” as:

One who employs an independent contractor to perform services for another which are accepted in the reasonable belief that the services are being rendered by the employer or by his servants, is subject to liability for physical harm caused by the negligence of the contractor in supplying such services, to the same extent as though the employer were supplying them himself or by his servants.

RESTATEMENT (SECOND) OF TORTS § 429 (1965).

⁶⁴ See Abraham & Weiler, *supra* note 54, at 387–88 (discussing situations in which courts have found emergency room physicians in independent contractor relationships with hospitals to be ostensible agents of the hospital).

⁶⁵ See Furrow, *supra* note 13, at 451–53 (discussing the under-pinnings of vicarious liability and agency law and the control and ostensible agency tests used to determine the nature of the physician-hospital relationship).

institution "holds out" the physician as an employee.⁶⁶ Although hospitals can take steps to obviate the appearance of a principal-agent relationship to avoid liability via agency theories,⁶⁷ these theories tend to be well-received by the courts and provide plaintiffs with an actionable theory of recovery.⁶⁸

3. Corporate Negligence

Plaintiffs have sought to hold hospitals and MCOs accountable for poor quality care under corporate negligence theories. At the heart of the corporate negligence doctrine is the hospital and MCO's duty to the public to evaluate physicians, grant staff privileges, and control and supervise staff physicians in a non-negligent manner.⁶⁹ Failure to exercise reasonable care in the performance of these and other corporate functions may give rise to a cause of action under corporate negligence. Corporate negligence also contemplates a healthcare institution's duty to provide adequate equipment and operating procedures to ensure patient safety.⁷⁰

Several cases illustrate the theory of corporate negligence. In *Darling v. Charleston Community Memorial Hospital*, for example, a college football player was treated for a broken leg by the defendant-hospital.⁷¹ The plaintiff's leg was amputated as a result of the misapplication of a plaster cast and the failure of the hospital's doctors and nurses to recognize and treat a progressive gangrenous condition.⁷² The *Darling* court found a duty on the part of the hospital to review the attending physician's work and to require consultations among physicians and nurses.⁷³ More recently, the California Court of Appeals endorsed a corporate

⁶⁶ See Noah, *supra* note 43, at 1240–42 (discussing ostensible agency theories).

⁶⁷ For example, the *Ohio Revised Code* provides that the lack of "notice or knowledge" necessary for the assertion of an "ostensible agency" or "agency by estoppel" claim may be precluded by the following notice: "[p]hysicians who render professional services to you in (name of hospital) are independent practitioners and are not employees or agents of the hospital. (name of hospital) is not responsible for the acts or omissions of physicians that are not directed or controlled by (name of hospital)." OHIO REVISED CODE § 2307.48(B)(1) (Anderson Supp. 1997).

⁶⁸ See *Boyd v. Albert Einstein Med. Ctr.*, 547 A.2d 1229, 1232 (Pa. Super. Ct. 1988) (describing factors indicative of an ostensible agency relationship between a physician and a hospital).

⁶⁹ See Stern, *supra* note 58, at 1289–91 (discussing corporate negligence doctrine); see also Furrow, *supra* note 13, at 457 (discussing duties that arise under the theory of corporate negligence).

⁷⁰ See Furrow, *supra* note 13, at 459–60 (describing negligence flowing to the health care institution from management and control of corporate policies and personnel).

⁷¹ See 211 N.E.2d 253 (Ill. 1965).

⁷² See *id.* at 255–56.

⁷³ See *id.* at 258; see also Griner, *supra* note 59, at 895–97 (discussing corporate negligence and the *Darling* decision); Havighurst, *supra* note 16, at 601–03 (discussing

negligence theory against an insurance company in *Wilson v. Blue Cross of Southern California*.⁷⁴ In *Wilson*, plaintiff's decedent, suffering from clinical depression, drug dependency, and anorexia, committed suicide after his insurance company refused to cover in-patient care against the advice of the treating physician.⁷⁵ The *Wilson* court allowed the issue of "whether the conduct of the decedent's insurance company... was a substantial factor in causing the decedent's death" to go to the jury.⁷⁶ In so holding, the court limited an earlier holding and bolstered the viability of corporate negligence as an avenue of recovery against hospitals and MCOs for injuries resulting from negligent treatment.⁷⁷

4. Other Theories of Liability

In addition to the theories discussed above, there are a number of other causes of action available to plaintiffs injured either directly or indirectly by MCO cost-containment policies. One alternative is tortious interference with the physician-patient relationship. A cause of action may arise under this theory when "the managed care system compromises the providers' relationship with an enrollee [such that] the system itself has at least negligently and perhaps recklessly interfered with the basic fiduciary relationship between the patient and the doctor."⁷⁸ In *Hammonds v. Aetna Casualty & Surety Co.*, the court found that such a claim might be actionable when a physician refuses to treat a patient as a result of intimidation on the part of the patient's insurer.⁷⁹ Other theories of recovery against MCOs include, *inter alia*, negligent misrepresentation, insurance bad faith, infliction of emotional distress, breach of contract, defamation, and claims brought under anti-trust law.⁸⁰

corporate negligence and the *Darling* decision).

⁷⁴ 271 Cal. Rptr. 876 (Cal. Ct. App. 1990).

⁷⁵ See *id.* at 877-78.

⁷⁶ *Id.* at 878.

⁷⁷ In *Wickline v. State*, the California Court of Appeals declined to extend liability for malpractice to a state-operated MCO on the grounds that physicians are solely responsible for treatment outcomes and that MCOs do not participate in treatment decisions. See 239 Cal. Rptr. 810 (Cal. Ct. App. 1986). However, the court entertained the idea that "[t]hird party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms as, for example, when appeals on a patient's behalf... are arbitrarily ignored or unreasonably disregarded or overridden." *Id.* at 819; see also Danzon, *supra* note 21, at 507 (discussing the implications of the *Wickline* decision).

⁷⁸ Stern, *supra* note 58, at 1295.

⁷⁹ See 237 F. Supp. 96 (N.D. Ohio 1965).

⁸⁰ See Stern, *supra* note 58, at 1295-97 (describing causes of action against MCOs arising under tortious interference with the physician-patient relationship and negligent misrepresentation); Tiano, *supra* note 30, at 89-100 (describing causes of action against MCOs

B. Inadequacies of the Current State of Managed Care Liability

1. Vicarious Liability and Agency-Based Liability

As the above discussion demonstrates, plaintiffs have an array of options at their disposal to hold MCOs liable for their role in adverse healthcare outcomes. However, these theories of liability are inadequate because they fail to address and recognize the *direct* role that MCOs play in the healthcare system. Under agency theories of liability, plaintiffs may only reach MCOs by first going after the physician. If a plaintiff can recover sufficient damages from the physician, it is unlikely that the plaintiff will take the extra step of pressing a claim against the MCO. Therefore, MCOs can use physicians as a shield against vicarious liability.⁸¹ Vicarious liability also fails to exert a deterrent effect upon negligent utilization review decisions. Indirect liability allows utilization review to escape scrutiny by concentrating on the acts of the physicians and ignoring the organizational cost-containment policies. Thus, the current law enables MCOs to continue to practice utilization review in the shadows and away from the light of accountability and potential liability. Additionally, vicarious liability theories provide insufficient avenues of recovery when the physician acts properly and the source of the injury originates at the management level of the MCO. In these cases, the plaintiff is forced to seek recovery against a non-negligent physician and is effectively prevented from reaching the culpable managed care entity.

In summary, vicarious liability and agency theories inadequately serve the interests of contemporary managed care systems for several reasons. First, physicians and other healthcare providers, like the treating physicians in *Pappas*,⁸² are in a frustrating and untenable position. These physicians unfairly find themselves named as defendants in instances where they provided the best possible care in light of the restrictions imposed by the MCO. Second, because vicarious liability theories require negligence on the part of the individual healthcare professional, these theories are not viable options when the MCO is responsible for the majority of the injury or the case against the individual practitioner is weak. Finally, indirect liability unjustly shifts the liability for poor patient outcomes to physicians and maintains the legal fiction that MCOs bear only indirect, if any, responsibility when their cost-containment policies result in

arising under breach of contract, insurance bad faith, infliction of emotional distress, defamation, interference with contract, and anti-trust).

⁸¹ In *Wickline v. State*, for example, a California Court of Appeals held that physicians, and not managed care entities, are ultimately responsible for medically inappropriate decisions resulting from cost containment mechanisms. In imposing a duty on the part of physicians to ignore medically inappropriate utilization review decisions, the court effectively placed the physician in a position to shield MCOs against liability. See *Wickline v. State*, 239 Cal. Rptr. 810, 819–20 (Cal. Ct. App. 1986).

⁸² *Pappas v. Asbel*, 675 A.2d 711 (Pa. Super. Ct. 1996).

harm to patients. In case after case, MCOs clearly play a direct and profound role in adverse patient outcomes when cost-containment policies and decisions cause physicians to fall below the standard of care. Yet, vicarious liability and agency-based liability have proved ineffective at deterring such conduct and remediating the resulting harm.⁸³

2. *Direct Tort Liability and Contract Remedies*

Currently available theories of direct MCO liability are also insufficient for plaintiffs whose injuries stem from breakdowns in managed care. Utilization review procedures are not negligent *per se*. Therefore, direct corporate negligence is not amenable to situations involving a failure of an otherwise non-negligent review system. In most cases, utilization review decisions result in care that meets the minimum standard of care. When, as in *Pappas*, an erroneous utilization review decision results in injury, recovery is more logically predicated upon malpractice than upon corporate negligence. In these cases, the issue is not the implementation of a defective system that would give rise to a corporate negligence claim.⁸⁴ Rather, the issue is analogous to a classic case of medical malpractice in which a negligent utilization review determination causes injury. The fact that the negligence is committed by an MCO, and not a physician, merely acknowledges the reality that MCOs are engaged in the practice of medicine.

While patients may also pursue contract remedies directly against MCOs, these remedies are limited to enforcement of the terms of the contract or to money or coverage due under the contract.⁸⁵ In a case like *Pappas*, for example, a plaintiff's recovery is limited to the amount of coverage and services wrongfully denied. Such recovery is grossly inadequate to compensate individuals who suffer grievous, debilitating, life-long injuries.

C. *The Case for Direct Negligent Utilization Review Liability for MCOs*

It has been suggested that the tort system does a poor job of resolving managed care quality issues.⁸⁶ Alternate regulatory and compensatory schemes based upon other bodies of law have been proposed as an alternative to tort liability. One commentator, for example, has denounced the extension of tort liability to MCOs on the grounds that to do so would cause increasing

⁸³ See Havighurst, *supra* note 16, at 596–611 (describing the ineffectiveness of agency liability in improving quality of care in both the hospital and managed care contexts).

⁸⁴ See *supra* notes 69–77 and accompanying text (discussing corporate negligence).

⁸⁵ Under the civil enforcement provision of ERISA, for example, recovery is limited to “benefits due to [the enrollee] under the terms of [the enrollee’s] plan.” 29 U.S.C. § 1132(a)(1)(B) (1994).

⁸⁶ See Danzon, *supra* note 21, at 507–08.

interference with physician autonomy.⁸⁷ However, such a proposal ignores the fact that physician autonomy is already significantly diminished under managed care. Other proposals include the establishment of a "cost constraints" defense to liability and the immunization of MCOs in malpractice cases.⁸⁸ The recognition of a cost constraints defense would essentially give MCOs license to implement utilization review standards that brazenly place profit over patient safety. Furthermore, such a defense would remove any market incentives to internalize the potential costs of adverse outcomes and provide reasonable access to appropriate healthcare. Immunizing MCOs from tort liability is antithetical to notions of fairness, justice, and accountability and ignores the fact that MCOs play a direct and substantial role in treatment decisions.⁸⁹ Contractual remedies have also been proposed as a solution to bring patient/enrollee expectations into conformity with the care available through their MCOs.⁹⁰ These contract remedies focus on the intent of the patient at the time of enrollment in the managed care plan.⁹¹ The intent of the enrollee is based upon the predicted risk and probability of future disease and injury.⁹² However, contract-based remedies ignore the fact that managed care enrollees are seldom familiar with the terms of their coverage and give little thought to unforeseeable catastrophic illness or injury. Therefore, contract-based strategies for resolving managed care quality issues are illusory.

Non-tort-based solutions for improving the quality of managed care plans ignore the powerful role that tort law can play in affecting pro-social changes in the healthcare industry.⁹³ In *Helling v. Carey*, for example, the Supreme Court of Washington, in a medical malpractice action against an ophthalmologist, redefined and improved the standard of care regarding glaucoma testing for persons under the age of forty.⁹⁴ This pro-patient change in the standard of care,

⁸⁷ See Noah, *supra* note 43, at 1250.

⁸⁸ See *id.* at 1250–51 ("Permitting MCOs to assert cost constraints as a defense to liability or granting total immunity from suit to these organizations under certain circumstances may represent the most sensible solution to the pressing problems of access and quality.").

⁸⁹ See Havighurst, *supra* note 16, at 627 (proposing legislation that would not "permit MCOs to hide behind the fiction that MCO-selected physicians work for patients, not for a corporate health plan"). But see Noah, *supra* note 43, at 1250 ("Extending tort liability to [MCOs] may have the perverse effect of increasing their interference with physician autonomy.").

⁹⁰ See Clark C. Havighurst, *Altering the Applicable Standard of Care*, 49 LAW & CONTEMP. PROBS. 265, 272–75 (1986) (suggesting a contractual strategy to define the liability of MCOs).

⁹¹ See Danzon, *supra* note 21, at 508–09.

⁹² See *id.*

⁹³ See Hirshfeld & Thomason, *supra* note 15, at 10 (discussing the power of the courts to make value judgments regarding the necessity of medical care).

⁹⁴ See *Helling v. Carey*, 519 P.2d 981 (Wash. 1974) (en banc).

as it related to glaucoma testing, resulted from fear of exposure to tort liability because it became less expensive to screen every patient for glaucoma than to pay large tort judgments for failure to diagnose. Direct MCO liability has the potential to facilitate similar improvements to patient access and quality of care in the managed care system. Under a direct liability scheme, MCOs would be forced to consider the costs of a potential lawsuit that would result from an erroneous cost-containment decision. The economic pressure of such a consideration would shift the analytical balance to favor quality of care and positive patient outcomes and disfavor parsimonious and unreasonable cost-containment policies. It would simply be cheaper for MCOs to provide higher quality healthcare and relieve physicians of burdensome practice restrictions than to pay tort judgments flowing from less expensive and lower quality care. Direct liability would effectively beat the managed care industry at its own game by underscoring the impact of quality of care issues in the cost-savings equation.

While the law continues to view the healthcare industry in an antiquated fee-for-service fashion, the reality of managed care has emerged to shift the balance of power from physicians to MCOs while leaving courts and legislatures stuck in the past.⁹⁵ Without direct MCO liability for negligent utilization review decisions, physicians will continue to bear a disproportionate share of responsibility in a healthcare delivery system that is increasingly beyond their control. Meanwhile, patients will be harmed as MCOs continue to enjoy the benefits of control untempered by the burdens of responsibility.⁹⁶ By recognizing direct negligent utilization review claims against MCOs, legislatures and courts can bring tort law into harmony with the realities of our nation's managed care system.⁹⁷ Describing the propriety of direct MCO tort liability, one commentator has eloquently noted that "an MCO has too many ways to influence the clinical decisions of medical specialists to permit it to deny that it is in the business of practicing medicine or otherwise to escape liability for breakdowns of the system over which it presides."⁹⁸

⁹⁵ See Havighurst, *supra* note 16, at 611–21 (comparing and contrasting the legal structure and framework of fee-for-service systems and managed care systems).

⁹⁶ See Hirshfeld & Thomason, *supra* note 15, at 42.

⁹⁷ See Henry, *supra* note 21, at 716–17 (discussing the positive aspects of direct MCO liability); Hirshfeld & Thomason, *supra* note 15, at 39 (describing how economic pressures in the managed care industry may result in narrowly construed definitions of "necessary care" and a greater incentive to withhold treatments).

⁹⁸ Havighurst, *supra* note 16, at 618.

IV. ERISA PREEMPTION DOES NOT BAR CLAIMS AGAINST MANAGED CARE ORGANIZATIONS FOR NEGLIGENT UTILIZATION REVIEW DECISIONS

A. *ERISA Preemption in the Managed Care Industry*

Direct liability for negligent utilization review decisions by MCOs serves both the interests of the public and the interests of healthcare professionals. In spite of the benefits of direct MCO liability, a number of obstacles prevent plaintiffs from proceeding directly against MCOs. Strategically, medical malpractice plaintiffs tend to overlook the role of MCOs and focus their cause of action on the role of the physician or hospital. Moreover, plaintiffs may be reluctant to seek recovery against an MCO if adequate compensation can be obtained solely from the physician.

Perhaps the most onerous barrier to direct MCO liability involves ERISA's preemption clause.⁹⁹ Typically, MCOs rely on ERISA procedurally to remove malpractice claims from state courts to federal courts and then use ERISA as a shield to preempt the claims.¹⁰⁰ Many federal circuit and district courts have demonstrated a willingness to broadly construe ERISA preemption. Thus, defendant-MCOs have a strategic advantage over plaintiffs in federal courts, which are often more receptive to an ERISA preemption defense. This "remove and preempt" tactic has several unfortunate consequences. First, removal of state medical malpractice claims to federal court under federal question jurisdiction represents an inconvenience to plaintiffs and can be misused as a delaying tactic by defendant-MCOs. Second, ERISA preemption allows MCOs to successfully challenge malpractice claims on strictly procedural grounds. As a result, plaintiffs are denied the opportunity to substantively confront MCOs regarding the

⁹⁹ ERISA's preemption clause provides, in part, that "the provisions of this subchapter . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . ." 29 U.S.C. § 1144(a) (1994).

¹⁰⁰ See *Franchise Tax Bd. of the State of Cal. v. Construction Laborers Vacation Trust for S. Cal.*, 463 U.S. 1, 19–20 (1983). The *Franchise Tax Board* Court stated:

Federal courts have regularly taken original jurisdiction . . . if the . . . suit would necessarily present a federal question. Section 502(a)(3) of ERISA specifically grants trustees of ERISA-covered plans . . . a cause of action for injunctive relief when their rights and duties under ERISA are at issue, and that action is exclusively governed by federal law.

Id.; see also *Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995) (seeking writ of mandamus in order to argue federal question jurisdiction and preemption defense under ERISA); *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995) (appealing defendant's removal to federal court and preemption defense under ERISA); *Kuhl v. Lincoln Nat'l Health Plan of Kan. City, Inc.*, 999 F.2d 298 (8th Cir. 1993) (claiming both federal question jurisdiction and preemption defense under ERISA); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992) (claiming preemption defense under ERISA).

consequences of their cost-containment decisions. Finally, by providing an escape hatch from malpractice claims, ERISA preemption allows MCOs to unfairly abandon their physicians who, as a result, are left to face the plaintiff's charges alone. Because most courts have held that medical malpractice claims against MCOs are preempted, many plaintiffs are unwilling to seek recovery against an MCO in jurisdictions that extend ERISA preemption to defeat malpractice claims. However, a closer analysis of recent preemption trends reveals that ERISA's preemption clause does not bar malpractice claims against MCOs or any other claims when the central issue is quality of care.

The doctrine of preemption holds that, under certain circumstances, state law must give way to federal law.¹⁰¹ Preemption is rooted in the Supremacy Clause of the United States Constitution,¹⁰² and the United States Supreme Court has recognized the preemptive effect of federal law over state law since the early nineteenth century.¹⁰³ A limited application of preemption preserves the regulatory powers of the individual states. Conversely, an expansive application of preemption allows for a comprehensive regulatory role on the part of the federal government. A sweeping federal regulatory role in the ERISA context, however, has denied managed care enrollees avenues of meaningful recovery for adverse healthcare outcomes.

Preemption can be either express¹⁰⁴ or implied.¹⁰⁵ Express preemption occurs where a statute contains explicit language that addresses the relationship between the federal law and the laws of the states. Express preemption analysis

¹⁰¹ See LAURENCE H. TRIBE, *AMERICAN CONSTITUTIONAL LAW* § 6-25, at 479 (2d ed. 1988).

¹⁰² The Supremacy Clause of the United States Constitution states as follows:

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

U.S. CONST. art. VI, cl. 2.

¹⁰³ See *Gibbons v. Ogden*, 22 U.S. 1, 211 (1824) (describing the operation of the Supremacy Clause in relation to state regulation as "[t]he appropriate application of . . . the clause . . . is to such acts of the State Legislatures as do . . . interfere with, or are contrary to the laws of Congress, made in pursuance of the Constitution, or some treaty made under authority of the United States. In every such case, the act of Congress . . . is supreme; and the law of the State . . . must yield to it.").

¹⁰⁴ See *Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977) (holding that Congress's intent to preempt state law may be "explicitly stated in the statute's language . . .").

¹⁰⁵ See TRIBE, *supra* note 101, § 6-25, at 479; see also *Pacific Gas & Elec. Co. v. State Energy Resources Conservation & Dev. Comm'n*, 461 U.S. 190, 204 (1983); *Fidelity Fed. Sav. & Loan Ass'n v. De la Cuesta*, 458 U.S. 141, 153 (1982); *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947).

concentrates on the language of the statute in question in order to determine the extent to which state law is preempted. Although ERISA contains an express preemption clause, most courts have looked beyond the statutory language of the clause in order to reach implied preemption considerations.

There are two varieties of implied preemption: conflict preemption and occupation-of-the-field preemption.¹⁰⁶ Conflict preemption exists where a state regulation directly contradicts an act of Congress¹⁰⁷ or where the state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.¹⁰⁸ Courts have found incongruity between state and federal regulations when state law has the effect of discouraging conduct that congressional action seeks to encourage.¹⁰⁹ State regulations that encourage certain conduct may be preempted if the banning of such conduct advances a congressional purpose.¹¹⁰ Also, courts may preempt a state regulation to facilitate national, uniform regulatory standards.¹¹¹ Even if a state regulation is completely in harmony with a federal scheme, the regulation may still be preempted if Congress intends to occupy the field that is the subject of the regulation.¹¹² Currently, ERISA preemption analysis in the majority of the courts is of the occupation-of-the-field variety. Although the scope of occupation-of-the-field preemption varies from subject to subject,¹¹³ the basic principle is that state law is void if it touches an area that Congress intends to completely monopolize via federal regulation.¹¹⁴ Thus, courts finding ERISA preemption of claims against MCOs point to Congress's purported intent to wholly occupy the area of

¹⁰⁶ See *TRIBE*, *supra* note 101, § 6-25, at 479.

¹⁰⁷ See *id.* § 6-26, at 481.

¹⁰⁸ See *Hines v. Davidowitz*, 312 U.S. 52, 67–68 (1941) (“Our primary function is to determine whether, under the circumstances of this particular case, Pennsylvania’s law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.”).

¹⁰⁹ See *TRIBE*, *supra* note 101, § 6-26, at 482–84.

¹¹⁰ See *id.* § 6-26, at 485–86.

¹¹¹ See *id.* § 6-26, at 486–97.

¹¹² See *id.* § 6-27, at 497–501.

¹¹³ See *id.* § 6-27, at 497–98. *Tribe* explains:

The less comprehensive is a federal regulatory scheme, the more likely it is that a holding ousting state jurisdiction would create a substantial legal vacuum—and hence, the less likely is such a holding.... Conversely, where a multiplicity of federal statutes or regulations govern a field, the pervasiveness of such federal laws will help to sustain a conclusion that Congress intended to exercise exclusive control over the subject matter.

Id.

¹¹⁴ See *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947) (“[T]he Act of Congress may touch a field in which the federal interest is so dominant that the federal system will be assumed to preclude enforcement of state laws on the same subject.”).

employee benefit plan regulation as a bar to all state laws, including causes of action brought under state law.

B. Preemption Analysis and Cipollone v. Liggett Group, Inc.

Prior to 1992, courts tended to bar state regulations and causes of action by a broad application of the preemption doctrine.¹¹⁵ For example, in *Pacific Gas & Electric Co. v. State Energy Resources Conservation & Development Commission*, the United States Supreme Court found the Atomic Energy Act preempted all state safety regulations of nuclear power plants.¹¹⁶ The Court retreated somewhat from this position one year later in *Silkwood v. Keer-McGee Corp.*, holding that punitive damages were not preempted under the Atomic Energy Act.¹¹⁷ However, in the area of employee benefit plans governed by ERISA (such as MCOs), courts continued to hold that state medical malpractice claims were preempted.¹¹⁸ Such a broadly construed concept of preemption left managed care enrollees, like Pappas, with little chance of recovery against MCOs for poor healthcare outcomes.

The United States Supreme Court's decisions in *Cipollone v. Liggett Group, Inc.*¹¹⁹ and in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*¹²⁰ signal an end to unfettered preemption, both generally and in the ERISA context, and offer hope for justice and accountability when patients are harmed by MCO cost-containment decisions. The issue that the

¹¹⁵ See Kurt B. Chadwell, *Automobile Passive Restraint Claims Post-Cipollone: An End to the Federal Preemption Defense*, 46 BAYLOR L. REV. 141, 153-65 (1994) (discussing preemption and airbag cases prior to 1992); Rudy Fabian, Comment, *Federal Preemption: Car-Makers' Cushion Against Air Bag Claims?*, 27 DUQ. L. REV. 299 (1989) (discussing the doctrine of preemption and its relation to automobile safety claims as they were understood in the late 1980s).

¹¹⁶ See 461 U.S. 190, 191 (1983).

¹¹⁷ See 464 U.S. 238, 238 (1984).

¹¹⁸ See *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995); *Kuhl v. Lincoln Nat'l Health Plan of Kan. City, Inc.*, 999 F.2d 298 (8th Cir. 1993); *Corcoran v. United Health Care, Inc.* 965 F.2d 1321 (5th Cir. 1992); *Butler v. Wu*, 853 F. Supp. 125 (D.N.J. 1994); *Visconti v. U.S. Health Care*, 857 F. Supp. 1097 (E.D. Pa. 1994); *Ricci v. Gooberman*, 840 F. Supp. 316 (D.N.J. 1993). But see *Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995); *Edelen v. Osterman*, 943 F. Supp. 75 (D.D.C. 1996); *Ouellette v. Christ Hosp.*, 942 F. Supp. 1160 (S.D. Ohio 1996); *Roessert v. Health Net*, 929 F. Supp. 343 (N.D. Cal. 1996); *Chaghervand v. Carefirst*, 909 F. Supp. 304 (D. Md. 1995); *Jackson v. Roseman*, 878 F. Supp. 820 (D. Md. 1995); *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544 (S.D. Ill. 1994); *Dearmas v. Av-Med, Inc.*, 865 F. Supp. 816 (S.D. Fla. 1994); *Kearney v. U.S. Healthcare, Inc.*, 859 F. Supp. 182 (E.D. Pa. 1994); *Smith v. HMO Great Lakes*, 852 F. Supp. 669 (N.D. Ill. 1994); *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983 (E.D. Pa. 1990).

¹¹⁹ 505 U.S. 504 (1992).

¹²⁰ 514 U.S. 645 (1995).

United States Supreme Court sought to resolve in *Cipollone* was whether the Federal Cigarette Labeling and Advertising Act preempted Cipollone's common law claims against the cigarette manufacturers.¹²¹ In reaching its decision, the Court prescribed the proper manner in which to approach preemption issues when the statute contains an express preemption provision—as is the case with ERISA.¹²² First, the Court acknowledged the presumption against preemption.¹²³ Citing *Rice v. Santa Fe Elevator Corp.*, the Court wrote, “[c]onsideration of issues arising under the Supremacy Clause ‘start[s] with the assumption that the historic police powers of the States [are] not to be superseded by . . . Federal Act [sic] unless that [is] the clear and manifest purpose of Congress.’”¹²⁴ Next, the Court focused on the preemption provision of the Federal Cigarette Labeling and Advertising Act.¹²⁵ Congress explicitly addressed the preemption issue in the Act; thus, the Court saw no reason to infer implied preemption¹²⁶ or to extend its analysis beyond an interpretation of the provision itself.¹²⁷ This left only the question of express preemption to be resolved through principles of statutory interpretation.¹²⁸ The Court described its analysis as a fair, but narrow,

¹²¹ See *Cipollone*, 505 U.S. at 508.

¹²² See *id.* at 524–30 (finding partial preemption of Cipollone's failure to warn claim, no preemption of the breach of express warranty claim, preemption of only one of the two theories of the fraudulent misrepresentation claim, no preemption of another theory of fraudulent misrepresentation, and no preemption of the conspiracy claim).

¹²³ See *id.* at 516 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947) and *Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978)).

¹²⁴ *Id.* (alteration in original) (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)).

¹²⁵ See *id.* at 517 (quoting *California Fed. Sav. & Loan Ass'n v. Guerra*, 479 U.S. 272, 282 (1987) and *Malone v. White Motor Corp.*, 435 U.S. 497, 505 (1978)). The *Cipollone* Court explained:

When Congress has considered the issue of pre-emption and has included in the enacted legislation a provision explicitly addressing that issue, and when that provision provides a “reliable indicium of congressional intent with respect to state authority” . . . “there is no need to infer congressional intent to pre-empt state laws from the substantive provisions” of the legislation.

Id. (citations omitted). See generally 15 U.S.C. § 1334 (1994) (preempting state law under the Cigarette Labeling and Advertising Act).

¹²⁶ See *id.* (“[W]e need only identify the domain expressly pre-empted . . .”).

¹²⁷ See *id.* (“Such reasoning is a variant of the familiar principle of *expressio unius est exclusio alterius*: Congress’ enactment of a provision defining the pre-emptive reach of a statute implies that matters beyond that reach are not pre-empted.”).

¹²⁸ See Lars Noah, *Reconceptualizing Federal Preemption of Tort Claims as the Government Standards Defense*, 37 WM. & MARY L. REV. 903, 914 (1996) (“[T]he Supreme Court in *Cipollone* viewed its task as limited to interpreting the scope of the statutory language . . .”).

construction of the precise language of the preemption provision in light of the strong presumption against preemption.¹²⁹ In defining the preemptive scope of such express preemption provisions, the Court noted that "each phrase within that clause limits the universe of common-law claims pre-empted by the statute."¹³⁰

The Court's analysis of preemption in *Cipollone* was a welcomed departure from the way courts previously approached the issue.¹³¹ Past decisions focused on the purpose and intent of federal regulations to find preemption of state common law actions.¹³² Other courts emphasized the desirability of a uniform, national scheme as grounds to bar state common law claims.¹³³ Still, other courts found preemption by equating state common law tort judgment with state regulations.¹³⁴ Although the *Cipollone* Court acknowledged that damage awards can operate to govern conduct as effectively as legislative enactments, the Court concluded that such awards were not necessarily preempted.¹³⁵ In *Cipollone*, the Court precluded a finding of implied preemption and abandoned uniformity, intent, and *de facto* regulatory concerns in favor of strict statutory interpretation when the statute in question contains an express preemption provision.¹³⁶

¹²⁹ See *Cipollone*, 505 U.S. at 523.

¹³⁰ *Id.* at 524.

¹³¹ See Chadwell, *supra* note 115, at 168 (discussing the Court's critique of and departure from the reasoning of the Third Circuit); Susan J. Stabile, *Preemption of State Law by Federal Law: A Task for Congress or the Courts?*, 40 VILL. L. REV. 1, 60 (1995) ("In *Cipollone*, the Supreme Court resolved the conflict that existed in the lower courts, effectively rejecting the approach taken, not only by a number of lower courts in analyzing the . . . Cigarette Act, but also by courts interpreting the preemptive reach of other federal statutes with express preemption provisions.").

¹³² See Chadwell, *supra* note 115, at 158-59 (discussing judicial interpretation of congressional intent regarding federal occupation of the field of automobile safety).

¹³³ See *Wood v. General Motors Corp.*, 865 F.2d 395, 419 (1st Cir. 1988) (preempting a product liability claim and stating "if Congress intended . . . to create [a] dual system of regulation, plaintiff fails to explain why Congress forbade state agencies from setting standards nonidentical to the federal standards . . .").

¹³⁴ See Timothy Wilton, *Federalism Issues in "No Airbag" Tort Claims: Preemption and Reciprocal Comity*, 61 NOTRE DAME L. REV. 1, 17-19 (1986) (discussing the potential for state safety standards to be enforced through a variety of methods, including jury verdicts in common law actions).

¹³⁵ See *Cipollone*, 505 U.S. at 521 (quoting *San Diego Bldg. Trades Council v. Garmon*, 359 U.S. 236, 247 (1959)).

¹³⁶ See Chadwell, *supra* note 115, at 168 ("[T]he Court defined its task in narrow terms, stating that it 'need only identify the domain expressly preempted by each' of the respective preemption sections . . ."); Stabile, *supra* note 131, at 60 ("The Court noted that there is no need to examine further the substantive provisions of the legislation to infer congressional intent to preempt state law when Congress has included in the legislation a provision explicitly addressing preemption . . .").

C. Preemption and ERISA in the Post-Cipollone Era

The evolution of preemption jurisprudence, which culminated in the *Cipollone* decision, unfortunately has not been entirely reflected in the area of ERISA preemption. In other contexts, most notably automobile safety and tobacco regulation, preemption has been limited in scope by a narrow interpretation of the express preemptive language where the relevant statute contains a preemption clause.¹³⁷ In ERISA preemption cases, the majority of courts continue to read the limiting language of ERISA's preemption provision,¹³⁸ in conjunction with the savings clause,¹³⁹ the deemer clause,¹⁴⁰ and the civil enforcement provision,¹⁴¹ in an overly expansive manner or ignore the language entirely in order to find virtually limitless implied preemption. These courts extend ERISA's preemptive scope far beyond what the statute mandates and disregard the *Cipollone* Court's guidance concerning proper preemption analysis. As a result, the majority of federal circuit courts have given MCOs a refuge from accountability and liability for their cost-containment decisions and have denied plaintiffs the opportunity to seek redress from truly culpable parties when they are injured by those decisions.

Passed in 1974, ERISA was intended to safeguard the financial solvency of employee pension plans.¹⁴² Almost as an afterthought, healthcare plans, and later

¹³⁷ See, e.g., *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504 (1992) (construing the preemption clause of the Federal Cigarette Labeling and Advertising Act); *Wilson v. Pleasant*, 660 N.E.2d 327 (Ind. 1995) (construing the preemption clause of the Federal National Traffic and Motor Vehicle Safety Act).

¹³⁸ See *supra* note 99.

¹³⁹ ERISA's savings clause provides that "[e]xcept as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A) (1994).

¹⁴⁰ ERISA's deemer clause provides that:

Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title . . . , nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for the purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. § 1144(b)(2)(B) (1994).

¹⁴¹ ERISA's civil enforcement provision provides that "[a] civil action may be brought by a participant or beneficiary to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B) (1994).

¹⁴² See Pittman, *supra* note 22, at 358–59. Pittman states that:

In enacting ERISA, Congress' primary purpose was to protect employees from

managed care plans provided via employment compensation, were incorporated into ERISA's regulatory scheme.¹⁴³ The United States Supreme Court addressed the preemptive reach of ERISA in 1983 in *Shaw v. Delta Air Lines, Inc.*¹⁴⁴ Concentrating on the "relate to" language of ERISA's preemption provision, the *Shaw* Court found that ERISA preempted New York's Human Rights Law, a comprehensive anti-discrimination statute, and Disability Benefits Law, a statute mandating certain employee benefits.¹⁴⁵ In so holding, the Court found that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan."¹⁴⁶ Despite this exceedingly broad definition of the "relate to" language and the expansive concept of ERISA preemption, the *Shaw* Court did concede that "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan."¹⁴⁷

The *Shaw* concept of ERISA preemption, with its illimitable construction of the "relate to" language, was reaffirmed by a unanimous Court in *Pilot Life Insurance Co. v. Dedeaux*.¹⁴⁸ In addition to finding preemption of Dedeaux's common law causes of action against his health insurer for tortious breach of contract, breach of fiduciary duties, and fraud,¹⁴⁹ the Court went further in finding that:

Congress clearly expressed an intent that the civil enforcement provisions of ERISA . . . be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries . . . and that varying state causes of action for claims within the scope of [the civil enforcement provisions of ERISA] would pose an obstacle to

administrative and funding abuses while establishing fair vesting requirements for pensions At the time of its enactment, ERISA was heralded as "nothing less than a pension 'bill of rights' to which every worker—regardless of his [or her] occupation, salary, or status—is entitled."

Id. (footnotes omitted).

¹⁴³ See *id.* at 360 ("There is no indication in the language of ERISA's preemption clause, or in ERISA's legislative history, that employers and benefit plans were to obtain some self-promoting protection from state law regulations."). ERISA defines "employee welfare benefit plan" and "welfare plan," in part, as "any plan, fund, or program . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, [or] death . . ." 29 U.S.C. § 1002(1)(A) (1994).

¹⁴⁴ 463 U.S. 85 (1983).

¹⁴⁵ See *id.* at 96.

¹⁴⁶ See *id.* at 96–97.

¹⁴⁷ *Id.* at 100 n.21.

¹⁴⁸ 481 U.S. 41 (1987).

¹⁴⁹ See *id.* at 47.

the purposes and objectives of Congress.¹⁵⁰

In the wake of *Shaw* and *Pilot Life*, virtually any claim that mentioned an ERISA-covered health plan was deemed to “relate to” the plan and was, thus, preempted by the overly-expansive concept of ERISA preemption. Additionally, claims against health plans and MCOs were confined to ERISA’s inadequate civil enforcement provision. Plaintiffs were left without an adequate means in which to seek recovery against MCOs, and individual states were unable to regulate and safeguard the quality of healthcare provided by MCOs.

Three years after *Pilot Life*, the Court reaffirmed *Shaw*’s broad definition of “relate to” and its advocacy of a sweeping scope of ERISA preemption in *Ingersoll-Rand Co. v. McClendon*.¹⁵¹ However, the *Ingersoll-Rand* Court did show a willingness to entertain the notion that some state laws were beyond ERISA’s preemptive grasp.¹⁵² Thus, the *Ingersoll-Rand* decision began the end of unchecked ERISA preemption by recognizing limits to ERISA’s preemption clause. The stage was set for the Court’s decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*¹⁵³

D. Resolving the Competing Views of ERISA Preemption

At the time the Court decided *Travelers*, the federal circuits were divided, and continue to be divided, over the appropriate scope of ERISA preemption. The majority of circuits advocate an expansive view of ERISA’s “relate to” language or look to extra-textual sources in order to preempt state causes of action against MCOs.¹⁵⁴ For example, in *Kuhl v. Lincoln National Health Plan of Kansas City*,

¹⁵⁰ *Id.* at 52.

¹⁵¹ 498 U.S. 133, 139 (1990) (“A law ‘relates to’ an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan.”) (citing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96–97 (1983)).

¹⁵² *See id.* The *Ingersoll-Rand* Court stated:

Notwithstanding its breadth, we have recognized limits to ERISA’s pre-emption clause. In *Mackey v. Lanier Collection Agency & Service, Inc.*, the Court held that ERISA did not pre-empt a State’s general garnishment statute, even though it was applied to collect judgments against plan participants. The fact that collection might burden the administration of a plan did not, by itself, compel pre-emption. Moreover, under the plain language of [ERISA’s preemption clause] the Court has held that only state laws that relate to benefit *plans* are pre-empted. Thus, even though a state law required payment of severance benefits, which would normally fall within the purview of ERISA, it was not pre-empted because the statute did not require the establishment or maintenance of an ongoing plan.

Id. (citations omitted).

¹⁵³ 514 U.S. 645 (1995).

¹⁵⁴ *See, e.g.*, *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996);

Inc., the Eight Circuit opted against strict statutory interpretation and characterized the resolution of ERISA preemption issues as a "question of legislative intent."¹⁵⁵ The *Kuhl* court found "no doubt" of Congress's intent that "the preemption clause . . . be construed extremely broadly."¹⁵⁶ Even courts that limited their analysis to the text of ERISA found a wide reach of preemption. In *Tolton v. American Biodyne, Inc.*, the Sixth Circuit seized upon ERISA's "relate to" phrase as the beginning and end of ERISA preemption analysis.¹⁵⁷ Even though the *Tolton* court acknowledged that their concept of ERISA preemption limited plaintiffs in MCO liability cases to recovery under ERISA's civil enforcement provision and left them "without a meaningful remedy,"¹⁵⁸ the court found that because Tolton's cause of action arose "from [the MCO's] refusal to authorize . . . benefits . . . under the plan," Tolton's claim "related to" an ERISA plan and was, thus, preempted.¹⁵⁹ These majority jurisdictions stretch the meaning of "relate to" to its farthest possible reaches and rely on a purported Congressional intent to keep all ERISA issues strictly within the realm of federal regulation. As a result, these circuits construe ERISA to provide a shield for defendant-MCOs that defeats any claims brought under state law for injuries arising out of utilization review and cost-containment decisions.

In a minority of circuits, however, state causes of action against MCOs survive based on a much narrower reading of the ERISA preemption provision.¹⁶⁰ The Tenth Circuit, in *Airparts Co. v. Custom Benefit Services of Austin, Inc.*, delineated four distinct types of laws that fall within the ambit of the "relate to" language of ERISA's preemption clause.¹⁶¹ The laws that "relate to" ERISA plans, in the view of the *Airparts* court, all involve regulation of the structure, terms, benefits, or administration of employee benefit plans. Thus, according to the *Airparts* court, laws that do not directly touch upon these areas do not "relate to" the plan and are not preempted. The court further noted that laws of "general applicability . . . that involve traditional areas of state

Tolton v. American Biodyne, Inc., 48 F.3d 937, 942-43 (6th Cir. 1995); *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708 (2d Cir. 1994); *Kuhl v. Lincoln Nat'l Health Plan of Kan. City, Inc.*, 999 F.2d 298 (8th Cir. 1993); *Spain v. Aetna Life Ins. Co.*, 13 F.3d 310 (9th Cir. 1993); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992).

¹⁵⁵ 999 F.2d at 301.

¹⁵⁶ *Id.*

¹⁵⁷ *See* 48 F.3d at 942-43.

¹⁵⁸ *Id.* at 943.

¹⁵⁹ *See id.* at 942.

¹⁶⁰ *See, e.g., Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995); *Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Airparts Co. v. Custom Benefit Serv. of Austin, Inc.*, 28 F.3d 1062 (10th Cir. 1994); *United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Mem'l Hosp.*, 995 F.2d 1179 (3d Cir. 1993); *Painters of Phila. Dist. Council No. 21 Welfare Fund v. Price Waterhouse*, 879 F.2d 1146 (3d Cir. 1989).

¹⁶¹ *See Airparts Co.*, 28 F.3d at 1064-65.

regulation,” such as medical malpractice and healthcare quality, do not “relate to” ERISA plans and suffer no preemption.¹⁶² The Tenth Circuit reaffirmed this analysis in *Pacificare of Oklahoma, Inc. v. Burrage* and added that malpractice claims are “too tenuous, remote, or peripheral” to ERISA’s regulatory scheme to trigger preemption.¹⁶³ Courts endorsing a more limited scope of ERISA preemption strike an equitable balance between the federal government’s legitimate need for national, uniform regulation of employee benefit plans with the state’s interest in safeguarding the quality of the healthcare delivery system for its citizens.¹⁶⁴ Thus, plaintiffs in minority jurisdictions can reasonably recover against MCOs for poor healthcare quality arising out of cost-containment considerations without upsetting the legitimate aim of ERISA’s regulatory scheme.

Both the majority and minority positions discussed above are supported by compelling authority and reasonable, albeit competing, interpretations of the “relate to” phrase of ERISA’s preemption provision. However, the majority of circuits that have examined the issue of ERISA preemption ignore the lessons of the United States Supreme Court. Circuits that preempt claims against MCOs have reached the wrong conclusion as a result of their failure to follow the preemption analysis outlined in *Cipollone* and further refined in *Travelers*.

The *Travelers* Court, like the *Cipollone* Court, began its analysis by acknowledging the long-standing presumption against preemption.¹⁶⁵ The Court next looked to the “relate to” language of the ERISA preemption clause. The Court concluded that if the “relate to” phrase was taken to its “furthest stretch of indeterminacy,” ERISA preemption “would never run its course.”¹⁶⁶ The Court then turned to the *Shaw*¹⁶⁷ definition of “relate to,” yet rejected its “connection with” language as unhelpful and vague.¹⁶⁸

Finding the language of ERISA’s preemption provision ambiguous, the Court turned to the legislative intent of ERISA to define its preemptive scope.¹⁶⁹ In

¹⁶² See *id.* at 1065 (quoting *National Elevator Ind., Inc. v. Calhoon*, 957 F.2d 1555, 1559 (10th Cir. 1992)).

¹⁶³ See *Pacificare of Okla., Inc.*, 59 F.3d at 154 (quoting *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 100 n.21 (1983)).

¹⁶⁴ See *Medtronic, Inc. v. Lohr*, 518 U.S. 470 (1996) (acknowledging that the regulation of health and safety is traditionally a state matter consistent with the historic police powers of the states to protect their citizens).

¹⁶⁵ See *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654 (1995) (“[W]e have never assumed lightly that Congress has derogated state regulation, but instead have addressed claims of pre-emption with the starting presumption that Congress does not intend to supplant state law.”).

¹⁶⁶ *Id.* at 655.

¹⁶⁷ *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96–97 (1983).

¹⁶⁸ See *Travelers*, 514 U.S. at 656.

¹⁶⁹ See *id.* at 656–57. The Court explained the objective of the ERISA preemption clause:

holding that the New York statute at issue, which imposed surcharges on ERISA plans, was not barred by preemption, the *Travelers* Court held that:

[N]othing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern [L]aws with only an *indirect economic effect* on . . . health insurance packages in a given State are a far cry from those "conflicting directives" from which Congress meant to insulate ERISA plans We therefore conclude that such state laws do not bear the requisite "connection with" ERISA plans to trigger pre-emption.¹⁷⁰

Although the *Travelers* decision concerned state surcharges on health plans, the Court's analysis is instructive on the proper relationship between negligence claims against MCOs and ERISA preemption. First, the *Travelers* Court was quite clear on the point that state causes of action that indirectly affect the administration of ERISA plans or that are generally applicable will survive ERISA preemption.¹⁷¹ Negligent utilization review claims do not address the

[as] described in the House of Representatives by a sponsor of the Act, Representative Dent, . . . to "eliminat[e] the threat of conflicting and inconsistent State and local regulation." Senator Williams made the same point, that "with the narrow exceptions specified in the bill, the substantive and enforcement provisions . . . are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans." The basic thrust of the pre-emption clause, then, was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.

Id. (citations omitted).

¹⁷⁰ *Id.* at 661–62 (emphasis added).

¹⁷¹ *See id.* The Court explained that:

Indeed, to read the pre-emption provision as displacing all state laws affecting costs and charges on the theory that they indirectly relate to ERISA plans that purchase insurance policies or HMO memberships that would cover such services, would effectively read the limiting language in § 514(a) out of the statute, a conclusion that would violate basic principles of statutory interpretation and could not be squared with our prior pronouncement that "[p]reemption does not occur . . . if the state law has only a tenuous, remote, or peripheral connection with covered plans, as is the case with many laws of general applicability." While Congress's extension of pre-emption to all "state laws relating to benefit plans" was meant to sweep more broadly than "state laws dealing with the subject matters covered by ERISA[,] reporting, disclosure, fiduciary responsibility, and the like," nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern

Id. (alteration in original) (citations omitted); *see also* Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825, 833 (1988) (noting that ERISA plans may be sued for "run-of-the-mill-state-law claims such as . . . torts committed by an ERISA plan . . .").

organizational or administrative aspects of managed care plans governed by ERISA. Rather, such claims address the quality of care delivered by MCOs and seek relief for plaintiffs, like Pappas, who are harmed as a result of plan policies or decisions. Thus, any impact that a negligent utilization review claim may have on an ERISA plan is decidedly indirect. Second, negligent utilization review claims against managed care entities impact both ERISA-covered and non-ERISA-covered managed care systems. Therefore, such causes of action are generally applicable and outside the scope of ERISA preemption as understood by the *Travelers* Court. Third, echoes of *Cipollone*'s endorsement of a fair, but narrow, construction of the precise language of preemption provisions in light of the strong presumption against preemption are found in the *Travelers* decision.¹⁷² To read ERISA's "relate to" phrase expansively to preempt negligent utilization review claims against MCOs is contrary to the fair and narrow construction of preemptive language advocated by the Court in *Travelers* and *Cipollone*. Moreover, such unduly broad preemption of negligent utilization review claims runs contrary to the state's interests in safeguarding healthcare quality and important federalist concerns that the Court implicated in its acknowledgment of the presumption against preemption. Fourth, the *Cipollone* Court clearly directs preemption analysis away from extra-textual concerns and supports the predominance of strict textual interpretation when the statute in question contains an express preemption provision.¹⁷³ Although the *Travelers* decision considered the legislative intent of ERISA after finding ambiguity in the text of the preemption clause, the Court's analysis is consistent with an emphasis on textualism and a strong reluctance to find boundless preemption based upon a slippery and ill-defined, extra-textual inquiry. Clearly, when ERISA preemption is analyzed against the background of *Cipollone* and *Travelers*, negligent utilization review claims against MCOs do not "relate to" ERISA plans within the meaning of the preemption provision and, thus, are not preempted.

When the evolution of ERISA preemption is considered in conjunction with the evolution of preemption generally, ERISA preemption no longer presents an obstacle to negligent utilization review claims against MCOs. As one circuit wrote, "laws of general application—not specifically targeting ERISA plans—that involve traditional areas of state regulation and do not affect 'relations among the principle ERISA entities—the employer, the plan, the plan fiduciaries, and the beneficiaries'—often are found not to 'relate to' an ERISA plan."¹⁷⁴ To allow MCOs to continue to use ERISA preemption as a refuge from liability overlooks the shrinking scope of preemption and ignores the Court's guidance on what it means to "relate to" an ERISA plan. As Pittman points out, negligent utilization

¹⁷² See *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 523 (1992).

¹⁷³ See *supra* note 136 and accompanying text.

¹⁷⁴ *Airparts Co. v. Custom Benefit Serv. of Austin, Inc.*, 28 F.3d 1062, 1065 (10th Cir. 1994) (quoting *Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550, 555–56 (6th Cir. 1987)).

review claims against MCOs should not be included in ERISA's preemptive reach because such claims (1) are traditionally a state, and not a federal, concern, (2) are generally applicable and only reach ERISA plans incidentally, and (3) do not affect relations between major ERISA participants.¹⁷⁵

V. PROPOSED TORT LIABILITY FOR NEGLIGENT UTILIZATION REVIEW DECISIONS

A. *The Cause of Action*

The implementation of MCO tort liability for utilization review decisions should be modeled on the tort of negligence or medical malpractice.¹⁷⁶ Such a framework comports with traditional notions of negligence as stated in the Restatement (Second) of Torts. The Restatement recognizes that one's interest in physical integrity and well-being is an interest "protected against . . . invasion."¹⁷⁷ This protected interest gives rise to a duty on the part of MCOs to refrain from invading that interest. Such duty stems from the fact that utilization review decisions implicate the protected interest by placing a patient's health and physical well-being at risk. Therefore, MCOs are under a duty to conduct utilization review determinations in a non-negligent manner.

Restatement section 291 analyzes the unreasonableness of an action, and hence its negligence, based upon a balancing of the risk of harm to another against the utility of the act and the manner in which the act is performed.¹⁷⁸ In the utilization review context, the risk of harm involves the consequences flowing from denial or delay of treatment and may include serious injury or death. The utility aspect of utilization review decisions includes financial savings and the elimination of unnecessary treatment and expenses. Under the Restatement position, the magnitude of the risk of delayed or denied treatment is so great that a utilization review determination that places cost containment over quality of care is unreasonable, and therefore, negligent.¹⁷⁹

Courts have defined negligence in the medical malpractice context as "unskillful practice resulting in injury to the patient, [caused by] a failure to exercise the 'required degree of care, skill and diligence' under the circumstances."¹⁸⁰ States that have imposed or attempted to impose MCO

¹⁷⁵ See Pittman, *supra* note 22, at 412-13 (discussing principles that exclude MCO tort liability from ERISA preemption).

¹⁷⁶ See generally RESTATEMENT (SECOND) OF TORTS § 281 (1965) (stating the elements of a cause of action for negligence).

¹⁷⁷ *Id.* § 281(a).

¹⁷⁸ See *id.* § 291.

¹⁷⁹ See *id.*

¹⁸⁰ FURROW, *supra* note 10, § 6-2, at 237 (citing *Wainwright v. Leary*, 623 So.2d 233, 237 (La. Ct. App. 1993), writ denied, 629 So.2d 1127 (La. 1993)).

liability statutorily have framed the issue of negligence in terms of a failure to exercise "ordinary care."¹⁸¹ This "ordinary care" standard is analogous to the "degree of care, skill and diligence" standard for medical malpractice cases. Ordinary care for utilization review decisions has been defined as the "degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice . . . would use in the same or similar circumstances."¹⁸² Under this standard, utilization review decisions that result in harm to patients would fall outside the purview of "ordinary care" and would give rise to an action for negligence. Conversely, utilization review determinations that reduce costs without negatively impacting patient outcomes would be within the scope of "ordinary care" and would not be actionable in tort.

Thus, under this proposed form of negligence for MCO utilization review decisions, an MCO is under a duty to make utilization review determinations in a "reasonable" manner and exercise "ordinary care." Where a utilization review determination results in harm to a patient, the analysis shifts to a twofold inquiry. The first issue is whether cost-containment considerations were given priority over healthcare quality and the patient's best interests. The second question is whether the denied or delayed treatment was the legal cause of the adverse outcome. Where these are the case, the utilization review decision is unreasonable and negligent in accordance with the Restatement position and actionable under a negligence theory.

B. *Proving the Cause of Action*

In medical malpractice cases, the standard of customary practice is established through the expert witness testimony of physicians.¹⁸³ Similarly, the "ordinary care" standard for utilization review decisions would be established by utilization review experts from within the managed care industry. In setting the standard, MCOs would be compelled to formulate criteria that account for both patient safety as well as financial considerations. Although such a scheme necessarily permits MCOs to set their own standards, this is unavoidable. As with medical malpractice standards, an uninformed evaluation of both the complexities of medically appropriate treatment and the economic constraints of managed care is insufficient to set a suitable standard of care for utilization review decisions.¹⁸⁴ Therefore, plaintiffs in negligent utilization review actions would be required to establish breach of the standard of care through the use of utilization review experts. In particularly egregious cases of denied or delayed treatment, however, a

¹⁸¹ See TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a) (West Supp. 1998); H.R. 677, 122d General Assembly, Reg. Sess. (Ohio 1998).

¹⁸² Ohio H.R. 677.

¹⁸³ See FURROW, *supra* note 10, § 6-2, at 241.

¹⁸⁴ See KEETON, *supra* note 58, § 32, at 189 (describing the rationale for permitting the medical profession to set its own legal standards of conduct).

plaintiff could establish negligent utilization review predicated upon a common knowledge or negligence *per se* basis.¹⁸⁵

C. Applying the Cause of Action

*Pappas*¹⁸⁶ provides an illustrative fact pattern for the proposed tort of negligent utilization review. Under this tort theory, Pappas would have a legally cognizable cause of action directly against the HMO. Additionally, with the removal of ERISA preemption, Pappas would have an opportunity to contest the propriety of his HMO's actions based on the substantive merits of the case. This cause of action would exist independent and separate from any liability involving the hospital or the physicians. Pappas would allege that (1) United States Healthcare, Inc. (USHC) had a duty to make their utilization review determination in a reasonable and non-negligent manner, (2) by denying and delaying appropriate treatment for the sake of cost containment, USHC breached its duty by making a negligent utilization review decision that failed to comport with the standard of "ordinary care," (3) the delayed treatment flowing from the negligent utilization review decision was the legal cause of Pappas's injuries, and (4) Pappas sustained compensable injuries as evidenced by his quadriplegia.

In proving and defending this cause of action, both the plaintiff and the defendant would primarily rely on the expert testimony of utilization review experts. This reliance on expert witnesses is analogous to the pivotal role played by experts in medical malpractice actions. The expert status of a utilization review witness would be predicated upon the witness's knowledge, skill, and training in both the clinical and fiscal aspects of managed care. An ideal utilization review expert would wear two hats: that of a physician and that of a healthcare economist. Such specialized knowledge would enable these expert witnesses to testify as to the appropriateness of a given utilization review decision in light of the competing clinical and financial considerations.

Assuming that the cause of action was not resolved before trial, Pappas's expert would testify that USHC's utilization review decision was negligent. In light of the surrounding circumstances, the need for prompt, specialized medical attention outweighed the cost savings achieved by the denial and delay of Pappas's treatment. In other words, it was unreasonable, and therefore negligent, for USHC to delay and deny the necessary and appropriate care. Conversely, USHC's expert would testify that, at the time the utilization review decision was rendered, it was reasonable to opt for cost savings over the physician's recommendations. Given the specific facts of *Pappas*, such testimony on the part of the defense would stretch credulity. However, in a closer case, the issue of the

¹⁸⁵ See FURROW, *supra* note 10, § 6-2, at 243-44 (describing various methods of proving a medical malpractice claim).

¹⁸⁶ *Pappas v. Asbel*, 675 A.2d 711 (Pa. Super. Ct. 1996).

negligence and appropriateness of a utilization review decision would likely be an open question ideally suited for resolution by the trier of fact.

VI. CONCLUSION

Despite the progress and innovations brought about by managed care, cost-containment policies continue to jeopardize the health of managed care enrollees and undermine the autonomy and clinical judgment of physicians. The current state of managed care liability has proven inadequate to correct these deficiencies. It is clear that liability for negligent utilization review decisions can bring about a much needed change in utilization review policies. With the erosion of preemption, courts should refrain from extending ERISA protection to MCOs against direct tort liability. By stripping away the ERISA shield, courts can clear the way for liability for negligent utilization review decisions. Tort liability would contribute to utilization review determinations by forcing MCOs to internalize the costs resulting from negligent decisions. The internalization of these costs would, in turn, motivate MCOs to opt for reasonable quality over unreasonable cost containment.

